

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 13708  
County Harriet  
Village or City Farmington (No. 78)

STATE OF MARYLAND  
CERTIFICATE OF DEATH 171

Registration Dist. No. 162

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Asa Bettinger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 21, 1876  
(Month) (Day) (Year)

7 AGE 39 yrs. — mos. — ds. 11 LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Day Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER John Bettinger

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Mary Spiker

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Winterberg

(Address) Grantville Ind

15 Filed Aug 23, 1915 Henry H. Baker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191.....  
that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

Had no residence in recently. Had gone to Cumberland Md to hospital for a few days and returned and died a few days later.  
(Duration) yrs. mos. ds.

Prob Cause Tuberculosis, if correct  
Contributory (Secondary)  
Reported to me  
(Duration) yrs. mos. ds.

(Signed) Henry H. Baker Registrar  
Aug 23, 1915 (Address) Grantville Ind

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethesda Chapel DATE OF BURIAL Aug 23, 1915

20 UNDERTAKER Wm Winterberg ADDRESS Grantville Ind

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Garrett County,  
Village or City Oakland Md (No. 8)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret Mary Cogan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH August 4th, 1914  
(Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Baby  
(b) General nature of industry, business, or establishment in which employed (or employer) -

9 BIRTHPLACE (State or country) Oakland Md

10 NAME OF FATHER W. R. Cogan

11 BIRTHPLACE OF FATHER (State or country) Piedmont W Va

12 MARDEN NAME OF MOTHER Rosalie Maroney

13 BIRTHPLACE OF MOTHER (State or country) Oakland Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W. R. Cogan  
(Address) Oakland Md

15 Filed Aug 6th, 1915 M. White  
S. L. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 4, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1915, to Aug 4, 1915,  
that I last saw her alive on Aug 4, 1915

and that death occurred on the date stated above, at 9P m.  
The CAUSE OF DEATH\* was as follows:

Pneumonia

Contributory (Secondary) Pneumonia, Leptos  
(Duration) yrs. 2 mos. 4 ds.

(Signed) McClure, M. D.  
Aug 5, 1915 (Address) Oakland

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oakland Md DATE OF BURIAL Aug 6, 1915

20 UNDERTAKER D. C. Bolden ADDRESS Oakland Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

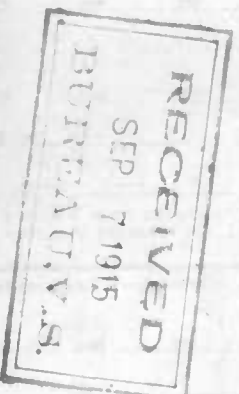
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma. Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 13710

County

Garrett

Village or City

Oakland

(No.

St.

Ward)

Registered No. 166

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Knox Cole

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Dec

11

1867

(Month)

(Day)

(Year)

7 AGE

47

yrs.

6

mos.

22

ds.

11 LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

West Virginia

10 NAME OF FATHER

Shadrick Cole

11 BIRTHPLACE OF FATHER (State or country)

West Virginia

12 MAIDEN NAME OF MOTHER

Elizabeth Bartlett

13 BIRTHPLACE OF MOTHER (State or country)

West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bessie Porter Cole

(Address)

Oakland, Md.

15

Filed Aug 2nd, 1915

Mark S. White

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 1

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

mat

1915

to

Aug 1

1915

that I last saw him alive on

July 31

1915

and that death occurred on the date stated above, at

39 m.

The CAUSE OF DEATH\* was as follows:

Chronic Myocarditis  
Acute Nephritis

(Duration)

5

yrs.

mos.

ds.

Contributory (Secondary)

Acute Infection

(Duration)

yrs.

3

mos.

ds.

(Signed)

M. S. Bartman

M. D.

Aug 2, 1915 (Address) Oakland, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore Md

DATE OF BURIAL

Aug 3, 1915

20 UNDERTAKER

W. C. Higgins

ADDRESS

Baltimore Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

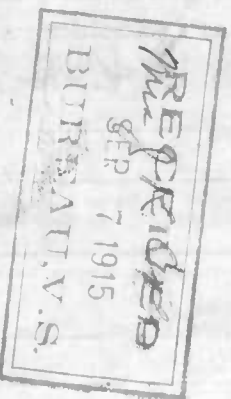
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Ovarian" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As thesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Gorrie Co

13711

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

166

Village or City

M Lake Pond

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Beatrice Ellen Cussett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

November 29

1909

(Month)

(Day)

(Year)

7 AGE

51

yrs.

5

mos.

2

ds.

If LESS than

1 day, .... hrs.

OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md.

## PARENTS

10 NAME OF FATHER

Upton Cussett

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Math West

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Upton Cussett

(Address)

Dance and Md

15

Filed

Aug. 2nd, 1915

M. White

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

1

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 7, 1915, to Aug 1, 1915,

that I last saw him alive on Aug 1, 1915,

and that death occurred on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH\* was as follows:

Tubercular meningitis

Contributory (Secondary)

(Duration) yrs. mos. 10 ds.

Tubercular meningitis &amp; suppurative

(Duration) yrs. mos. ds.

(Signed) M. C. Hines

Aug 2, 1915 (Address) Dance and Md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. 10 the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Flatwood Md

Aug 3, 1915

20 UNDERTAKER

ADDRESS

D. B. Borden

Baltimore, Md.

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*oma. Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confeiental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## PLACE OF DEATH

13712

County

Garrett

STATE OF MARYLAND  
CERTIFICATE OF DEATH.

Registration Dist. No.

Village or City

(No. ....)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## FULL NAME

Eulow

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

*Aug 24 1905*  
(Month) (Day) (Year)

7 AGE

*still born*  
.....yrs. ....mos. ....ds.

If LESS than  
1 day.....hrs.  
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

*Garrett Co Md*

## PARENTS

10 NAME OF FATHER

*Adolphus P Eulow*

11 BIRTHPLACE OF FATHER (State or country)

*Garrett Co Md*

12 MAIDEN NAME OF MOTHER

*M. May Cuppett*

13 BIRTHPLACE OF MOTHER (State or country)

*Garrett Co Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*A. Mason*

(Address)

*Frederick Md*

15

Filed

*Aug 24, 1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Aug 24 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191....., to ..... 191.....  
that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at *2:30* m.  
The CAUSE OF DEATH\* was as follows:

Contributory (Secondary)

(Duration) .....yrs. ....mos. ....ds.

(Signed)

*A. Mason*

, M. D.

*Aug 25th 1915* (Address) *Frederick Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Original*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 13713

County GarrettVillage or City Friendsville (No. 13)2 FULL NAME Clara B. FriendSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 161

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
(Write the word)

6 DATE OF BIRTH June 11, 1839  
(Month) (Day) (Year)

7 AGE 76 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Housework  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Samuel Sisler

11 BIRTHPLACE OF FATHER (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Barbara Wolf

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H Friend(Address) Friendsville Md

15 Filed Aug 15 1915 Wm H Friend  
Sacae REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 14 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1<sup>st</sup> 1915, to Aug 14 1915,

that I last saw him alive on Aug 14 1915,and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Arterial sclerosis  
(Duration) yrs. 8 mos. ds.

Contributory (Secondary) Erysipelas  
(Duration) yrs. 2 mos. ds.

(Signed) A. J. Mason, M. D.  
Aug 14 1915 (Address) Friendsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, at place of death

It not at place of death? Former or usual residence usual residence

19 PLACE OF BURIAL OR REMOVAL Blooming Rose DATE OF BURIAL August 16 1915

20 UNDERTAKER E. G. Horned ADDRESS Harzittown Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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*Original*

RECEIVED

SEP 2 1915

BUREAU, V. S.





# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Thantiton," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

13715

County

Garrett Co

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

166

Village or City

Mt Lake

(No.

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Susan Amanda Gregg

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

DATE OF BIRTH

July - 5<sup>th</sup>, 1839

AGE

76 1 5 If LESS than  
yrs. mos. ds. 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

BIRTHPLACE  
(State or country)

New York

## PARENTS

NAME OF FATHER

Smith

BIRTHPLACE OF FATHER  
(State or country)

do not know

MAIDEN NAME OF MOTHER

do not know

BIRTHPLACE OF MOTHER  
(State or country)

" " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Myron E Gregg

(Address)

Wash DC

Filed

Aug 10, 1915

Mt Lake

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug. 10<sup>th</sup>

(Month)

(Day)

1915 (Year)

I HEREBY CERTIFY, That I attended deceased from

Aug 4, 1915, to August 9, 1915

that I last saw her alive on August 9, 1915

and that death occurred on the date stated above, at 4 4, m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage

(Duration) ? yrs. mos. ds.

Contributory  
(Secondary)

(Duration) ? yrs. mos. ds.

(Signed)

H. E. McCombs, M. D.

Aug 10, 1915. (Address) Wash DC

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash DC Aug 11, 1915

UNDERTAKER

ADDRESS

W. E. Batchelor Wash DC

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

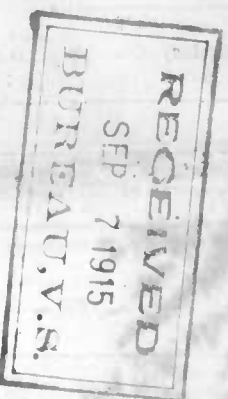
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

13716

County

Garrett

Village or City

Friendsville

(No. ....)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

161

St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Priscille Gury

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

## 6 DATE OF BIRTH

October

1843

(Month) (Day) (Year)

## 7 AGE

71 yrs.

9 mos.

— ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

House work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

Garrett co Md

## PARENTS

## 10 NAME OF FATHER

Jonathan Friend

11 BIRTHPLACE  
OF FATHER  
(State or country)

Garrett co Md

12 MAIDEN NAME  
OF MOTHER

Elizabeth Friend

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Delaware

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Gura

(Address)

Friendsville Md

## 15

Filed

Aug 3, 1915

J. H. Friend

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

August

3rd

1915

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

February 24th, 1914, to August 3rd, 1915.

that I last saw her alive on August 2nd, 1915.

and that death occurred on the date stated above, at 3 a m.

The CAUSE OF DEATH\* was as follows:

Pericarditis Chronic

(Duration) 1 yrs. 6 mos. ds.

Contributory  
(Secondary)

atheroma

(Duration) 2 yrs. 2 mos. ds.

(Signed)

Hilley Clayton N. Drew, M. D.

August 3rd, 1915 (Address) Friendsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death 8 yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, at place of death

Former or usual residence usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Friendsville Md August 14, 1915

## 20 UNDERTAKER

## ADDRESS

S. Savage Friendsville

Md

*Brink*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

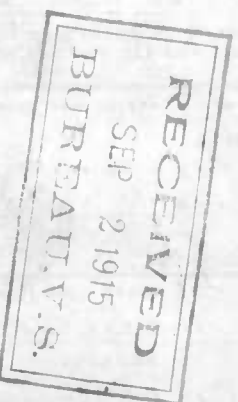
[Approved by U. S. Census and American Public Health  
Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County GarrettVillage or City Wheel Park (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 169

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hilda Beatty Hardisty

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 8-16-1904  
(Month) (Day) (Year)

7 AGE 10 yrs. 10 mos. 4 ds. 15 min. ?  
OR LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Garrettslee, Ind.

10 NAME OF FATHER J. S. Hardisty

11 BIRTHPLACE OF FATHER (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Ella Hardisty

13 BIRTHPLACE OF MOTHER (State or country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. S. Hardisty  
(Address) Wheel Park, Ind.

15 Filed Aug. 22, 1916 Imm. C. A. Ashley  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8-12-1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-28-1915 to 8-12-1915,

that I last saw her alive on 8-12-1915

and that death occurred on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH\* was as follows:

Rheumatism and  
worm condition, acute  
curculionid infestation  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds.

Contributory Primary Berna  
Secondary Auto Intoxication (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

(Signed) Edward J. Hallors, M. D.  
8-23-1915 (Address) Wheel Park, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hardisty Farm Dur Park DATE OF BURIAL \_\_\_\_\_, 1915

20 UNDERTAKER D. E. Bolden ADDRESS \_\_\_\_\_

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

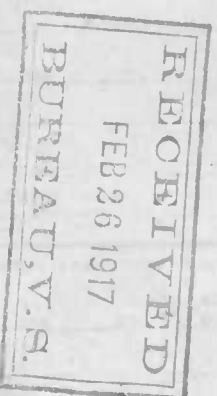
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mastitis* (disease causing death), 29. ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scabs, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Garett 14185 (151)  
Village or City Maysville (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
2 FULL NAME Lidie Harris

STATE OF MARYLAND  
CERTIFICATE OF DEATH  
Registration Dist. No. 172

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX rel 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 7, 1915  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 2 ds. OR LESS than 1 day, 7 hrs. min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER John Harris  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Alice Rose  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Harris  
(Address) Chappee wva

15 Filled Aug 9, 1915 9 15 P  
(1) W L R

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 7, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Baby is dead I knew nothing more never saw it before death  
Born alive lived 7 hours. Cause of death unknown  
(Duration) yrs. mos. ds.

Contributory (Secondary) 7 hours. Cause of death unknown  
(Signed) H P Copeland, M. D.  
Aug 9, 1915. (Address) Blaine Ave

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mount Zion DATE OF BURIAL Aug 9, 1915

20 UNDERTAKER John Harris ADDRESS Chappee wva

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

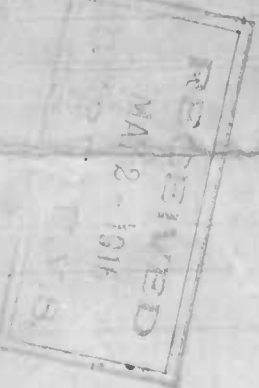
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Racina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 13717  
 County Garett  
 Village or City Maerill (No. 104) St.        Ward         
 2 FULL NAME William Harris  
 Registration Dist. No. 172  
 [If death occurred in the hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH May 7 1914  
 (Month) (Day) (Year)

7 AGE one yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15

Filed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 30 1915  
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 30 1915, to Aug. 1 1915, that I last saw him alive on Aug. 1 1915

and that death occurred on the date stated above, at        m.

The CAUSE OF DEATH\* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

## Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. L. Shepper, M. D.  
Aug. 2 1915 (Address) Kitzmillen, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mount Zion Aug. 2 1915

## 20 UNDERTAKER

## ADDRESS

John Harris Chaffer

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



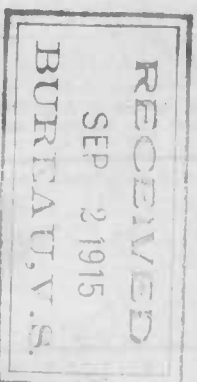
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

13718

County

*Baltimore*STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

*166*

Village or City

*Oakland*

(No. ....)

St; .....

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

*Thomas Gordon Hayes*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*Jan 5, 1844*  
(Month) (Day) (Year)

7 AGE

*70* yrs. *7* mos. *7* ds. *1* day, *7* hrs. *5* min. ?  
IF LESS THAN 1 day, .... hrs. .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Lawyer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)*Maryland*

## PARENTS

10 NAME OF FATHER

*Thomas G. Hayes*11 BIRTHPLACE OF FATHER  
(State or country)*Ida*

12 MAIDEN NAME OF MOTHER

*Julia Gordon*13 BIRTHPLACE OF MOTHER  
(State or country)*Ida*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Julia J. Hayes*

(Address)

*2901 St. Paul St., Balto.*

15

Filed

*Aug 28, 1915*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Aug 27, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Aug 1915*, to *Aug 1915*,  
that I last saw him alive on *Aug 27, 1915*and that death occurred on the date stated above, at *5:00* p. m.

The CAUSE OF DEATH\* was as follows:

*Heart Failure Acute*  
*Dilation*Contributory  
(Secondary)*Phlebotomy from Wandering*  
*W.B.*

(Signed)

*W. L. Broadwater*, M. D.  
*Aug 28, 1915* (Address) *Oakland*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Baltimore, Md*

DATE OF BURIAL

*8/30, 1915*

20 UNDERTAKER

*S. B. Bolden*

ADDRESS

*Oakland*

If more blanks are needed, address State Registrar, 8 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Garnett

13719

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

166

Village or City

Oakland

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wm. Howard Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

1

6 DATE OF BIRTH

Aug 23, 1915

7 AGE

1 day, 2 hrs.

It LESS than 1 day, 2 hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Chas Bowie Johnson

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Lennis M. Grant

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. W. McCormac

(Address)

Oakland, Md

15

Filed

Aug 23, 1915 M. White

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 23, 1915

17

I HEREBY CERTIFY, That I attended deceased from

64, to 1915, to 11 4, to 1915.

that I last saw him alive on Aug 23, 1915.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

H. W. McCormac

M. D.

Aug 23, 1915 (Address) Oakland, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oakland, Md.

Aug 23, 1915

20 UNDERTAKER

ADDRESS

W. E. Bobbitt

Oakland, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not spinfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29, ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

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1 PLACE OF DEATH

13720

County

Garrett County

53

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

Village or City

Oakland

(No.)

Md

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lawrence L. Loar

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Dec 17

(Month)

(Day)

1891  
1915 (Year)

7 AGE

23

yrs.

9

mos.

5

ds.

If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Clerk

(b) General nature of industry business, or establishment in which employed (or employer)

Clothing Store

9 BIRTHPLACE

(State or country)

Groffton W. Va

## PARENTS

10 NAME OF FATHER

L. L. Loar

11 BIRTHPLACE OF FATHER (State or country)

Oakland Md

12 MAIJOEN NAME OF MOTHER

Virginia Lee

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Loar

(Address)

Oakland Md

15

Filed

Aug 23rd 1915

Mar. White

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 22

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 21, 1915, to Aug 22, 1915,

that I last saw him alive on Aug 22, 1915,

and that death occurred on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH \* was as follows:

per coronary thrombosis  
 (Duration) 1 yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

M. J. Bradburn

M. D.

Aug 22 1915 (Address) Oakland Md

\* State the DISEASE CAUSING DEATH; or incidents from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Groffton W. Va

Aug 25, 1915

20 UNDERTAKER

ADDRESS

D. E. Beebe

Oakland Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

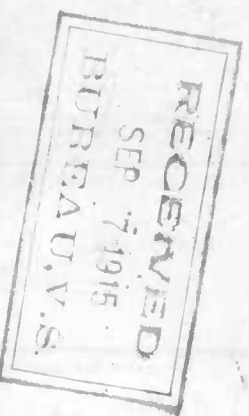
[Approved by U. S. Census and American Public Health Association.]

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*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tlæmus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Garrett</u>			13721			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Kitzmiller</u> (No. _____)			St.; _____ Ward)			Registration Dist. No. <u>172</u>		
2 FULL NAME <u>Vonnie Jay Long</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word)				
6 DATE OF BIRTH <u>August 27</u> , 18 <u>73</u> (Month) (Day) (Year)		7 AGE <u>41</u> yrs. <u>11</u> mos. <u>10</u> ds. If LESS than 1 day, _____ hrs. OR _____ mto. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>"</u>		9 BIRTHPLACE (State or country) <u>Virginia</u>						
PARENTS	10 NAME OF FATHER <u>Jacob Zeilor</u>		11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>					
	12 MAIDEN NAME OF MOTHER <u>Sophia Bohrer</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u>					
	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Long</u> (Address) <u>Kitzmiller, Md</u>							
15 Filed <u>Aug 11</u> , 191 <u>5</u>		REGISTRAR <u>A. G. B. R.</u>						
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>August 10</u> , 191 <u>5</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 9</u> , 191 <u>5</u> , to <u>Aug 10</u> , 191 <u>5</u> , that I last saw her alive on <u>Aug 10</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>4:15 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Acute Infectious Cholecystitis</u> (Probably) (Duration) _____ yrs. _____ mos. <u>30 hours</u>								
Contributory <u>Toxemia</u> Secondary (Duration) _____ yrs. _____ mos. _____ ds.								
(Signed) <u>E. Jackson Wilkin</u> , M. D. <u>Aug. 11</u> , 191 <u>5</u> (Address) <u>Kitzmiller, Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.								
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Kitzmiller, Md</u>						DATE OF BURIAL <u>Aug 12</u> , 191 <u>5</u>		
20 UNDERTAKER <u>Barwick &amp; Co.</u>						ADDRESS <u>Kitzmiller Md</u>		

①

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

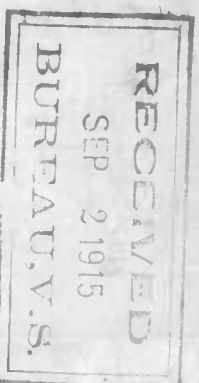
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**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Ricochet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

13722

County

Garrett

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 163

Village or City

County of Prince George's

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Andrew J. Michaels

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE,  
MARRIED,  
WIDOWED,  
DIVORCED  
(Write the word)

Married

DATE OF BIRTH

Feb. 26<sup>th</sup>

(Month) (Day)

1830

(Year)

AGE

85

yrs.

5

mos.

23

ds.

If LESS than

1 day.....hrs.

OR.....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE  
(State or country)

Allegheny, Md

PARENTS

10 NAME OF FATHER

George Michaels

11 BIRTHPLACE OF FATHER  
(State or country)

Allegheny, Md.

12 MAIDEN NAME OF MOTHER

Catherine Broadwater

13 BIRTHPLACE OF MOTHER  
(State or country)

Allegheny, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. C. Michaels

(Address)

Westernport, Md

15

Filed

Aug 26, 1915 Geo L Michaels, D

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug. 19<sup>th</sup>

(Month)

(Day)

1915

17

I HEREBY CERTIFY, That I attended deceased from

191

to

on Aug. 16-

1915-

that I last saw him alive on

Aug. 16-

1915-

and that death occurred on the date stated above, at 5-P-m.

The CAUSE OF DEATH\* was as follows:

Shock following broken hip due to fall on lawn

(Duration)

yrs.

mos.

3

ds.

Contributory  
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. J. Long

M. D.

(Address)

Piedmont, W. Va

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Michael's Cemetery

Aug. 22, 1915

20 UNDERTAKER

ADDRESS

W. H. Apedloock

Piedmont, W. Va

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. B. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Garrett</u>		13723		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hanover</u> (No. _____) St; _____ Ward)		Registered No. <u>167</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Rebecca Ann Shaffer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>May 26, 1938</u> (Month) (Day) (Year)					
7 AGE <u>57</u> yrs. <u>2</u> mos. <u>10</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Hanover Garrett Co. Md.</u>					
PARENTS	10 NAME OF FATHER <u>George Roth</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Ann Elizabeth Moss</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Dakota</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry A. Shaffer</u> (Address) <u>Oakland, Md. #2</u>					
15 Filed <u>August 7, 1915</u> <u>Regt. Latham</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>August 5, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>March</u> , 1915, to <u>August 5</u> , 1915, that I last saw her alive on <u>August 5</u> , 1915, and that death occurred on the date stated above, at <u>8:30 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Cyst of Pancreas</u>					
Contributory (Secondary) <u>Same</u> (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Anna A. Belvin</u> , M. D. <u>Aug 6, 1915</u> (Address) <u>Eggleston, Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Red House</u>				DATE OF BURIAL <u>August 8, 1915</u>	
20 UNDERTAKER <u>D. E. Bolden</u>				ADDRESS <u>Oakland</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automotive factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

*oma. Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Ovarian" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
SEP 7 1915  
BURF. AUT. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

13727

County

Garrett

Village or City

Friendsville Mo.

(No.

St.;

Ward)

Registration Dist. No. 16/

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Leon Ralph Sauers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Feb 8, 1915  
(Month) (Day) (Year)

7 AGE

5 yrs. 28 mos. 28 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Garrett Co. Md

PARENTS

10 NAME OF FATHER

J. M. M. Sauers

11 BIRTHPLACE OF FATHER (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Elizabeth Sliger

13 BIRTHPLACE OF MOTHER (State or country)

W. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. M. Sauers

(Address)

Friendsville Md

15

Filed

Aug 6, 1915 - J. M. M. Sauers  
Locust REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 6th, 1915  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 4th, 1915, to Aug 5th, 1915

that I last saw him alive on Aug 5th, 1915

and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Hemorrhage of bowels

(Duration) yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Mason, M. D.

Aug 6th, 1915 (Address) Friendsville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Restoring Rose Aug 7, 1915

20 UNDERTAKER

ADDRESS

J. M. Mason Friendsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MD.

*Original*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

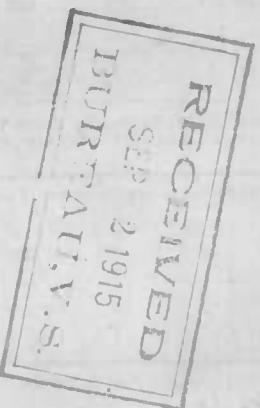
Approved by U. S. Census and American Public Health  
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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Transition," "Mars-inus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 13724

County GarrettVillage or City Trap run (No. 104)2 FULL NAME Thoyd Everett UpholdSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 161

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX mail 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH June 18, 1915  
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Garrett Co. Md

10 NAME OF FATHER Peter Uphold

11 BIRTHPLACE OF FATHER (State or country) W. Va

12 MAIDEN NAME OF MOTHER Bertha B. Leats

13 BIRTHPLACE OF MOTHER (State or country) W. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Uphold

(Address) Friendsville Md

15 Filed Aug 27, 1915 Local

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 26, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

No Physician in attendance  
Cholera infantum  
(Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) Thoyd Uphold Local Reg. M. D.  
Aug 27, 1915 (Address) Friendsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Usual Residence

19 PLACE OF BURIAL OR REMOVAL Keeler Glade DATE OF BURIAL Aug 27, 1915

20 UNDERTAKER W. Savage ADDRESS Friendsville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County

Village or City

(No.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

## 4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

## 7 AGE

If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15

Filed

1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 18 DATE OF DEATH

## 17 I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

## Contributory

Secondary

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20 UNOBTAINER

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

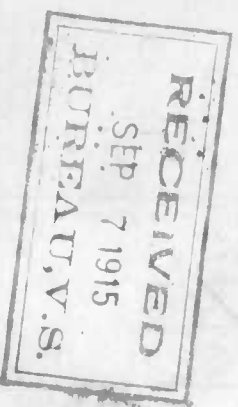
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plowman*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*gcs*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ). "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*. If *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as *accidental*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward

## 2 FULL NAME

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory Secondary

(Signed)

Aug 13, 1915

(Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

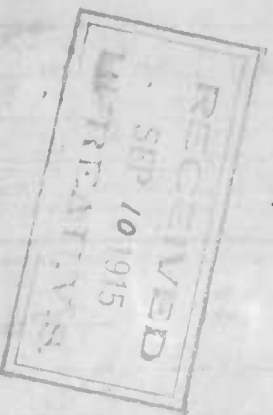
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 13726  
 County Garett (41)  
 Village or City Swanton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Phoebe Elizabeth Wilson  
 Registration Dist. No. 172  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH Oct 4, 1838  
 (Month) (Day) (Year)

7 AGE 76 yrs. 9 mos. 29 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) west Virginia

10 NAME OF FATHER Isaac Cunningham

11 BIRTHPLACE OF FATHER (State or country) W. V. A.

12 MAIDEN NAME OF MOTHER Margaret Louther

13 BIRTHPLACE OF MOTHER (State or country) W. V. A.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Cunningham

(Address) Swanton Md

15 Filed Aug 11, 1915 A. K. B.  
W. S. R. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 13, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1915 to Aug 1, 1915.

that I last saw him alive on Aug 1, 1915.

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Causes of bowels

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) H. P. Bohlen, M. D.

Aug 4, 1915 (Address) Blaine W. Va.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Turners Cemetery Aug 5, 1915

20 UNDERTAKER ADDRESS

Barriek & Company Ind. mitter

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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